fortable sensations. It is easily applied, is comfortable, and costs almost nothing. It may be worn constantly, being applied in the morning before rising, in which case it will prevent any possible atrophy of the testicle, or it may be worn only when the uncomfortable sensations are present. Under its constant use the volume of the veins about the testicle soon becomes reduced, while the testicle increases in size.

Article XVII.

Multiple Polypoid Fibroma of the Nymphæ; a Rare Case.

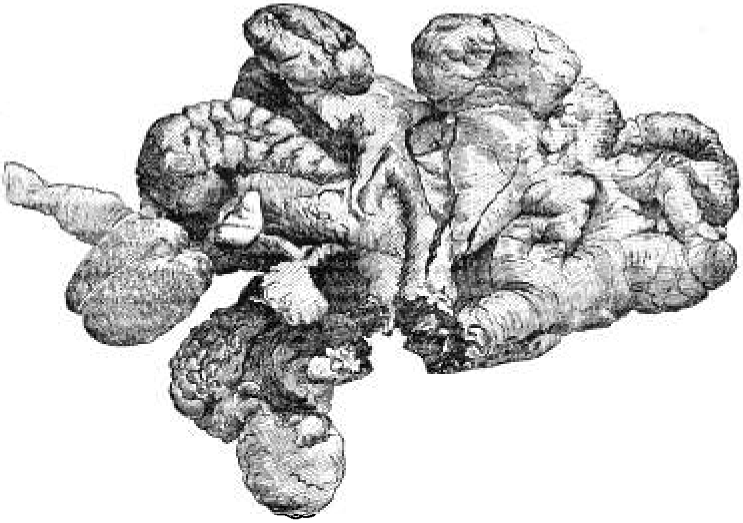
By B. F. Baer, M.D., Demonstrator of Clinical Gynæcology, Instructor in Gynæcology in the Post-Graduate Course, and Chief of Dispensary for the Diseases of Women in the University of Penna.; Obstetrician to the State Hospital for Women, Philadelphia.

M. S., æt. 39, is married and has had four children, the youngest of whom is eleven years of age. Her labours were all tedious, one of them requiring the aid of the forceps. She has been in delicate health since her first gestation. Her menses have always been regular, but she has had a profuse leucorrhœa since the birth of her last child. Her father died at the age of sixty of "consumption of the bowels," and her mother at fifty of "dropsy," the character of which I was unable to ascertain. She herself had a severe pulmonary hemorrhage eighteen years ago, after the labour with her first child, and one year since a slight hæmoptysis for one or two days. At times she has a slight cough. No history of syphilitic infection could be obtained, nor were there any symptoms of constitutional syphilis present in the case.

About four years ago she first discovered at the upper portion of the nymphæ, on either side of the clitoris, two growths about the size and shape of a small mulberry. These grew separately until they had attained a length of about two inches, when they became adherent to one another at their distal extremities first, and finally throughout their entire length. Within a few months after the discovery of this condition, she noticed a number of smaller growths of a like character sprouting out along the line of the labia minora. As each of these younger vegetations reached sufficient development they, in like manner, became adherent to one another at their extremities, and finally joined the parent or main growth. This mass grew to almost its present size during the first two years of its existence, its growth being very slow in the last two. About one year ago she became aware that the vaginal orifice was becoming obstructed by similar vegetations, and later the anal orifice became likewise involved.

She now, for the first time, consulted a physician, Dr. W. A. Davis, of Camden, who kindly asked me to see the case with him. With the patient in the dorsal position, and the parts exposed, the following condition presented itself to view. The labia majora were widely separated by an unsightly, irregularly lobulated mass, which reached from the clitoris to the anus, spreading out and entirely concealing the vaginal orifice.

Each lobule had a very uneven, hob-nailed surface, and that, together with its dark colour, makes it very much resemble elephantiasis in the negro. The whole mass seemed to take its origin from the nymphæ, both of which were involved alike. The clitoris could not be found, and it was probably lost in the growth or destroyed by pressure. The different parts making up this structure were larger at their extremities than at their points of origin, thus giving each lobule a club-shaped appearance. Examination of the under surface of this growth proved its origin to be in the nymphæ, and that it had a number of pedicles (see fig.). Some of these pedicles were adherent to one another along their entire length, while others were independent, the extremities only being attached to the main growth. In no instance was there an excrescence which was completely separate from the main growth, but in several the attachment was very slight. At a number of places there was an appearance as if the pedicle of a lobule had become attenuated by traction on it, and finally separating entirely, the clubbed extremity was left to derive a parasitic existence through its attachment to its fellow. The vaginal orifice, os urethræ, and anus were studded with growths of similar character. These were lighter in colour, and were not so firm on pressure as the remainder of the growth, due very probably to the fact that they were not exposed to the same extent. The skin occupying the coccygeal groove seemed to be undergoing a change in the same direction. The vagina, above the carunculæ myrtiformes, was entirely free from the disease. The skin covering the labia majora was thickened, but there was nothing else to indicate that it was likely to take part in this vegetating growth. These products were firm and elastic, but not hard. They were tender on pressure, though they had given rise to little or no pain during their development, when let alone. They did not appear to be very vascular, and at no time in their history did they bleed or ulcerate, but they were constantly moistened by a thin, fetid secretion from the surface.



The great inconvenience and suffering arising from this condition was interference with the functions of the parts involved, and for this mainly she sought relief. Surgical interference was advised, and on Feb. 23, 1881, with the patient anæsthetized, I proceeded to operate, being assisted by Drs. W. A. Davis, Wm. D. Robinson, and John S. Mabon. My purpose was to amputate the mass at its different points of attachment by a sort of flap operation, and then to bring the edges together by suture, and thus aim to get immediate union. But when I had removed the nymphæ at their lower portions, and had advanced upwards towards the clitoris, so much hemorrhage was met with that it was considered more prudent to finish the operation with the aid of the écraseur, which was done. After the mass was separated no hemorrhage occurred, though there was left a raw surface along the whole length of each nympha about half an inch in width, and a much larger surface at their junction above. The edges of the wound were brought together, as originally intended, by sutures, about twelve of which were required. I did not now, however, expect to secure union by first intention, for two reasons: first, because of the use of the écraseur; and second, because the skin was so toneless that the ligature cut through in several instances, when effort was made to bring the edges together, although very little force was required to do so. The knees were fastened together, and a suppository containing one grain of the aqueous extract of opium placed in the rectum, which was all the opium administered in the after-treatment of the case.

The pedicle, as seen in the specimen, gives a very inadequate idea of the real surface left to heal, as it did not spread out when released from the loop of the écraseur, as did the parts from which it was taken.

The after-treatment consisted in antiseptic precautions, good food, and quinia in tonic doses. On the fourth day, it was found that the sutures had cut out, and that union had, as feared, failed to take place. The wound finally healed by granulation, and the patient recovered better health than she had enjoyed for years; and in five months after the operation she became again pregnant, the last pregnancy having occurred eleven years before.

My friend Dr. H. F. Formad, to whom I sent the tumour for microscopic examination, gave me the following report: "The specimen must be classed with the *polypoid fibromata*, known also under the name of *fibroma molluscum*. It is made up exclusively of connective tissue in all its parts, and is covered all around by a thin membrane which has the structure of skin (minus the secretory elements and hairs). It has nothing in common with *papilloma* or with *elephantiasis*, except in macroscopic appearance, and differs from the latter by being pedicellated and containing no yellow elastic tissue. Under the microscope, the absence of yellow elastic tissue forms one of the main diagnostic points of fibroma from elephantiasis."

The only cases that I have been able to find recorded which somewhat resemble this specimen in shape and character are, first, that given and pictured by Virchow in his book on tumours (*Die Krankenhaften Geschwülste*, vol. i. p. 421), and that by Dr. H. F. Formad (*Trans. Path. Society of Phila.*, 1880). But in both of these cases the tumours did not exceed in size a small hen's-egg, and they were attached to the labium minorum by only one narrow pedicle, whilst in my case the tumour was attached by many pedicles to both labia minora. In both cases the tumours differed histologically from this specimen in being of myxomatous structure, whereas in my case the tumour showed a purely fibrous structure.

Another class of tumours, which have a certain macroscopic resemblance to the new formation in question are described by Virchow, l. c. p. 345, and termed "*acuminated condylomata.*" These occasionally also occur in polypoid, dendritic form, but differ in being in the main bulk made up of epithelium.

Elephantiasis arabum, which sometimes gives rise to tuberosities, the surface appearance of which is not unlike that of this tumour, according to Virchow, never gives rise to pedicellated formations, but always involves an organ in toto.

ARTICLE XVIII.

ON THE VARIETIES, MECHANISM, DIAGNOSTIC SIGNIFICANCE, ETC. OF THE MITRAL PRESYSTOLIC CARDIAC MURMUR. By AUSTIN FLINT, M.D., Professor of the Principles and Practice of Medicine and of Clinical Medicine in the Bellevue Hospital Medical College.

MY object in this article is to give a brief statement of conclusions, based on my own clinical observations, in respect to the mitral direct or presystolic cardiac murmur, and the points which I shall make are embraced in the following propositions :—

1. There are two varieties of this murmur, which are distinguished by differences in quality and in mechanism. One variety is a rough, and the other is a soft murmur.

2. The roughness in the first of these varieties is characteristic, and may be distinguished as vibratory or blubbering. It is imitated very closely by producing with the expired breath sonorous vibrations of the lips or of the tongue. The softness of the second variety is bellows-like, resembling that of other soft cardiac murmurs. This murmur may vary in pitch and intensity, but as a rule, it is low and weak.

3. The rough murmur is due to vibrations of the curtains of the mitral valve, caused by the passage of blood from the auricle to the ventricle. Hence, the modes just mentioned, of imitating the murmur, exemplify its mechanism as well as its vibratory or blubbering character. The soft murmur, like other bellows murmurs, may be due either to contraction of the orifice through which the blood passes, or to roughness of the surface over which it flows.

4. A rough presystolic murmur, in general, denotes a mitral obstructive lesion, the obstruction due to adhesion of the mitral curtains, leaving a